



TOWN OF STONINGTON

HEALTH DEPARTMENT

152 Elm Street • Stonington, Connecticut 06378

(860) 535-5010 • Fax (860) 535-1023

APPLICATION FOR FOOD SERVICE LICENSE

NAME OF ESTABLISHMENT: _____

ADDRESS: _____

TELEPHONE: _____ FAX: _____

EMAIL ADDRESS: _____

NAME OF OWNER: _____

ADDRESS: _____

TELEPHONE: _____

ESTABLISHMENT CLASS (CIRCLE): I II III IV

TYPE OF ESTABLISHMENT (CIRCLE): RESTAURANT BAR/CAFÉ DELI VENDOR

LODGING CATERER SCHOOL DAYCARE REST HOME CHURCH OTHER

MONTHS OF OPERATION (CIRCLE): YEAR ROUND SEASONAL*

* IF SEASONAL: FROM _____ TO _____

TOTAL SEATING CAPACITY: _____

QUALIFIED FOOD OPERATOR (QFO): _____
(CLASS III & IV ONLY)

DESIGNATED ALTERNATE QFO: _____

PLANS TO RENOVATE, REMODEL OR ALTER A FOOD SERVICE ESTABLISHMENT MUST BE SUBMITTED TO THE STONINGTON HEALTH DEPARTMENT FOR COMPLIANCE REVIEW WITH STATE AND LOCAL HEALTH CODES.

LICENSES ARE NOT TRANSFERABLE. A CHANGE IN OWNERSHIP OR LOCATION REQUIRES A NEW APPLICATION FOR LICENSURE. PLEASE KEEP THE STONINGTON HEALTH DEPARTMENT UPDATED ON INFORMATION PERTAINING TO YOUR LICENSE.

ANY LICENSE ISSUED PURSUANT TO THIS APPLICATION WILL BE SUBJECT TO APPLICABLE STATE AND LOCAL FOOD SERVICE REGULATIONS.

SIGNATURE OF APPLICANT/OWNER: _____ DATE: _____

TOWN APPROVAL SIGNATURE: _____ DATE: _____